STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003916	A. BUILDING: _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN ASSISTED LIVING COMMUNITY	2250 HARVEST MOON DR INDIANAPOLIS, IN 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey Dates: July 16 and 17, 2014 Facility Number: 003916 Provider Number: 003916 AIM Number: N/A Survey Team: Karina Gates Generalist TC Beth Walsh RN Tom Stauss RN Census Bed Type: Residential: 55 Total: 55 Census Payor Type: Medicaid: 40 Other: 15 Total: 55 Sample: 9 Autumn Glen Assisted Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 000		